This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 174010	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 12/27/2012 8:35 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RAINBOW MENTAL HEALTH FACILITY (174010) for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	31,869	0	0	109,436	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	31,869	0	0	109,436	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 12/27/2012 8:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2205 WEST 36TH AVENUE	PO Box:			1.00
2.00	City: KANSAS CITY	State: KS	Zip Code: 66103	County: WYANDOTTE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	RAINBOW MENTAL HEALTH FACILITY	174010	28140	4	07/01/1998	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
16.01	Hospital-Based Health Clinic - FQHC 1									16.01
16.02	Hospital-Based Health Clinic - FQHC 2									16.02
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2011	06/30/2012	20.00
21.00	Type of Control (see instructions)	10		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning: 1.00	Ending: 2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 12/27/2012 8:35 am

		Beginning:	Ending:	
		1.00	2.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 12/27/2012 8:35 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 12/27/2012 8:35 am

		1.00	2.00	3.00	
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00		
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	13,561	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00

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		1.00	2.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00 Name: SOCIAL & REHABILITATION SERVICES	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 5201	141.00
142.00 Street: 915 HARRISON	PO Box:		142.00
143.00 City: TOPEKA	State:	Zip Code: 66612	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

Name	County	State	Zip Code	CBSA	FTE/Campus	
0	1.00	2.00	3.00	4.00	5.00	

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		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 12/27/2012 8:35 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Description	Part A Y/N	Part A Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/28/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 12/27/2012 8:35 am

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?				Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DAN	MUFICH		41.00
42.00	Enter the employer/company name of the cost report preparer.		RAINBOW MENTAL MENTAL HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		913-755-7019	DAN.MUFICH@OSH.KS.GOV		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 12/27/2012 8:35 am

		Part B	
		Y/N	Date
		3.00	4.00
	PS&R Data		
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/28/2012
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	
			3.00
	Cost Report Preparer Contact Information		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		INTERIM CFO
42.00	Enter the employer/company name of the cost report preparer.		
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		

VOLUNTARY CONTACT INFORMATION | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part V | Date/Time Prepared: 12/27/2012 8:35 am

		1.00	
	Cost Report Preparer Contact Information		
1.00	First Name		1.00
2.00	Last Name		2.00
3.00	Title		3.00
4.00	Employer		4.00
5.00	Phone Number		5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1		8.00
9.00	Mailing Address 2		9.00
10.00	City		10.00
11.00	State		11.00
12.00	Zip		12.00
	Officer or Administrator of Provider Contact Information		
13.00	First Name	DAN	13.00
14.00	Last Name	MUFICH	14.00
15.00	Title	PROGRAM CONSULTANT	15.00
16.00	Employer	OSH	16.00
17.00	Phone Number	(913)755-7019	17.00
18.00	E-mail Address	DAN.MUFICH@OSH.KS.GOV	18.00
19.00	Department		19.00
20.00	Mailing Address 1	500 STATE HOSPITAL DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	OSAWATOMIE	22.00
23.00	State	KS	23.00
24.00	Zip	66064	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	36	13,176	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	13,176	0.00		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		36	13,176	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0			19.00
20.00	NURSING FACILITY	45.00	0	0			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00	HOSPICE	116.00	0	0			24.00
25.00	CMHC - CMHC	99.00					25.00
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
26.26	FQHC II	89.01					26.26
26.27	FQHC III	89.02					26.27
27.00	Total (sum of lines 14-26)		36				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,741	344	11,274		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF Subprovider		0	0			3.00
4.00	HMO IRF Subprovider		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,741	344	11,274		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0	1,741	344	11,274		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0		19.00
20.00	NURSING FACILITY	0		0	0		20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE		0	0	0		24.00
25.00	CMHC - CMHC	0	0	0	0		25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
26.26	FQHC II	0	0	0	0		26.26
26.27	FQHC III	0	0	0	0		26.27
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	0		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	109	1.00
2.00	HMO					0	2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	112.20	0.00	0	109	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00	NURSING FACILITY	0.00	0.00	0.00			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00	0.00	0.00			23.00
24.00	HOSPICE	0.00	0.00	0.00			24.00
25.00	CMHC - CMHC	0.00	0.00	0.00			25.00
26.00	RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
26.26	FQHC II	0.00	0.00	0.00			26.26
26.27	FQHC III	0.00	0.00	0.00			26.27
27.00	Total (sum of lines 14-26)	0.00	112.20	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	Discharges Title XIX	Discharges Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	20	628		1.00
2.00	HMO				2.00
3.00	HMO IPF Subprovider				3.00
4.00	HMO IRF Subprovider				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				5.00
6.00	Hospital Adults & Peds. Swing Bed NF				6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00	INTENSIVE CARE UNIT				8.00
9.00	CORONARY CARE UNIT				9.00
10.00	BURN INTENSIVE CARE UNIT				10.00
11.00	SURGICAL INTENSIVE CARE UNIT				11.00
12.00	OTHER SPECIAL CARE (SPECIFY)				12.00
13.00	NURSERY				13.00
14.00	Total (see instructions)	20	628		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
26.26	FQHC II				26.26
26.27	FQHC III				26.27
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		121,312	121,312	0	121,312	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,406	5,406	0	5,406	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	35,953	1,784,280	1,820,233	0	1,820,233	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	97,514	193,033	290,547	0	290,547	5.00
6.00	00600	MAINTENANCE & REPAIRS	79,637	171,859	251,496	0	251,496	6.00
7.00	00700	OPERATION OF PLANT	0	125,069	125,069	0	125,069	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26	26	0	26	8.00
9.00	00900	HOUSEKEEPING	130,532	14,216	144,748	0	144,748	9.00
10.00	01000	DIETARY	0	265,319	265,319	0	265,319	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	183,098	0	183,098	0	183,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,337	25,337	0	25,337	14.00
15.00	01500	PHARMACY	0	0	0	16,971	16,971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	171,517	380	171,897	0	171,897	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,484,805	162,341	3,647,146	-98,800	3,548,346	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,884	15,884	54.00
60.00	06000	LABORATORY	29,787	150	29,937	16,231	46,168	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	278	278	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,899	3,899	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,282	148,888	243,170	0	243,170	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	128,031	128,031	0	128,031	89.02
90.00	09000	CLINIC	0	0	0	13,167	13,167	90.00
91.00	09100	EMERGENCY	0	0	0	32,370	32,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,307,125	3,145,647	7,452,772	0	7,452,772	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	4,307,125	3,145,647	7,452,772	0	7,452,772	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	121,312	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	5,406	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	180,548	2,000,781	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	190,700	481,247	5.00
6.00	00600	MAINTENANCE & REPAIRS	11,224	262,720	6.00
7.00	00700	OPERATION OF PLANT	0	125,069	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,768	79,794	8.00
9.00	00900	HOUSEKEEPING	7,047	151,795	9.00
10.00	01000	DIETARY	12,076	277,395	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	183,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,834	54,171	14.00
15.00	01500	PHARMACY	22,395	39,366	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,420	178,317	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-13,309	3,535,037	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,884	54.00
60.00	06000	LABORATORY	12,202	58,370	60.00
66.00	06600	PHYSICAL THERAPY	0	278	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	3,899	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	243,170	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
89.01	08901	FQHC II	0	0	89.01
89.02	08902	FQHC III	0	128,031	89.02
90.00	09000	CLINIC	76,838	90,005	90.00
91.00	09100	EMERGENCY	0	32,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	614,743	8,067,515	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	614,743	8,067,515	200.00

RECLASSIFICATIONS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 12/27/2012 8:35 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OUTSIDE MEDICAL COSTS				
1.00	ADULTS & PEDIATRICS	30.00	0	14,708	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,884	2.00
3.00	LABORATORY	60.00	0	16,231	3.00
4.00	PHYSICAL THERAPY	66.00	0	278	4.00
5.00	ELECTROCARDIOLOGY	69.00	0	3,899	5.00
6.00	PHARMACY	15.00	0	16,971	6.00
7.00	CLINIC	90.00	0	13,167	7.00
8.00	EMERGENCY	91.00	0	32,370	8.00
	TOTALS		0	113,508	
500.00	Grand Total: Increases		0	113,508	500.00

RECLASSIFICATIONS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 12/27/2012 8:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OUTSIDE MEDICAL COSTS						
1.00	ADULTS & PEDIATRICS	30.00	0	113,508	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	113,508			
500.00	Grand Total: Decreases		0	113,508			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/27/2012 8:35 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	390,000	0	0	0	0	1.00
2.00	Land Improvements	400,266	0	0	0	0	2.00
3.00	Buildings and Fixtures	5,885,957	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	393,963	37,390	0	37,390	0	7.00
8.00	Subtotal (sum of lines 1-7)	7,070,186	37,390	0	37,390	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	7,070,186	37,390	0	37,390	0	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	121,312	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,406	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	126,718	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,221,619	0	1,221,619	0.171876	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,885,957	0	5,885,957	0.828124	0	2.00
3.00	Total (sum of lines 1-2)	7,107,576	0	7,107,576	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/27/2012 8:35 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	390,000	0				1.00
2.00	Land Improvements	400,266	0				2.00
3.00	Buildings and Fixtures	5,885,957	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	431,353	0				7.00
8.00	Subtotal (sum of lines 1-7)	7,107,576	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	7,107,576	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	121,312				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,406				2.00
3.00	Total (sum of lines 1-2)	0	126,718				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	121,312	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,406	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	126,718	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	121,312	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,406	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	126,718	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-2,791	ADMINISTRATIVE & GENERAL	5.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-66,533			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	53,137			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests		0		0.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-814	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	33.00
33.01	CURRENT YEAR VACATION ACCRUAL	A	158,070	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	PRIOR YEAR VACATION ACCRUAL	A	-179,150	ADMINISTRATIVE & GENERAL	5.00	33.02
33.05	CURRENT YEAR SALARY ACCRUAL	A	338,291	ADMINISTRATIVE & GENERAL	5.00	33.05
33.06	PRIOR YEAR SALARY ACCRUAL	A	-398,247	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07	CURRENT YEAR HOLIDAY ACCRUAL	A	18,264	ADMINISTRATIVE & GENERAL	5.00	33.07
33.08	PRIOR YEAR HOLIDAY ACCRUAL	A	-46,486	ADMINISTRATIVE & GENERAL	5.00	33.08
33.09	CURRENT COMPENSATORY LEAVE ACCRUAL	A	3,417	ADMINISTRATIVE & GENERAL	5.00	33.09
33.10	PRIOR YEAR COMPENSATORY LEAVE ACCRUA	A	-6,788	ADMINISTRATIVE & GENERAL	5.00	33.10
33.11	LAUNDRY PROVIDED BY 17-4004 OSAWATOM	A	66,572	LAUNDRY & LINEN SERVICE	8.00	33.11
33.12	OUTSIDE MEDICAL SERVICES	A	76,838	CLINIC	90.00	33.12
33.13	LAUNDRY COSTS TRANSFERRED FROM 17-40	A	13,196	LAUNDRY & LINEN SERVICE	8.00	33.13
33.14	LAUNDRY COSTS TRANSFERRED FROM 17-40	A	6,388	EMPLOYEE BENEFITS	4.00	33.14
33.15	OTHER COSTS TRANSFERRED FROM 17-4004	A	9,693	EMPLOYEE BENEFITS	4.00	33.15
33.16	OTHER COSTS TRANSFERRED FROM 17-4004	A	205,083	EMPLOYEE BENEFITS	4.00	33.16
33.17	OTHER COSTS TRANSFERRED FROM 17-4004	A	252,983	ADMINISTRATIVE & GENERAL	5.00	33.17
33.18	OTHER COSTS TRANSFERRED FROM 17-4004	A	11,224	MAINTENANCE & REPAIRS	6.00	33.18
33.19	OTHER COSTS TRANSFERRED FROM 17-4004	A	7,047	HOUSEKEEPING	9.00	33.19
33.20	OTHER COSTS TRANSFERRED FROM 17-4004	A	12,076	DIETARY	10.00	33.20
33.21	OTHER COSTS TRANSFERRED FROM 17-4004	A	28,834	CENTRAL SERVICES & SUPPLY	14.00	33.21
33.22	OTHER COSTS TRANSFERRED FROM 17-4004	A	7,234	MEDICAL RECORDS & LIBRARY	16.00	33.22
33.23	OTHER COSTS TRANSFERRED FROM 17-4004	A	163,220	ADULTS & PEDIATRICS	30.00	33.23

ADJUSTMENTS TO EXPENSES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
33.24	OTHER COSTS TRANSFERRED FROM 17-4004	A	12,202	LABORATORY	60.00	33.24
33.25	OTHER COSTS TRANSFERRED FROM 17-4004	A	22,395	PHARMACY	15.00	33.25
33.26	COSTS TRANSFERRED TO 17-4004	A	-109,996	ADULTS & PEDIATRICS	30.00	33.26
34.00	COSTS TRANSFERRED TO 17-4004	A	-40,616	EMPLOYEE BENEFITS	4.00	34.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		614,743			50.00

ADJUSTMENTS TO EXPENSES	Provider CCN: 174010	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8 Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	Wkst. A-7 Ref.		
		5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)	0		33.00
33.01	CURRENT YEAR VACATION ACCRUAL	0		33.01
33.02	PRIOR YEAR VACATION ACCRUAL	0		33.02
33.05	CURRENT YEAR SALARY ACCRUAL	0		33.05
33.06	PRIOR YEAR SALARY ACCRUAL	0		33.06
33.07	CURRENT YEAR HOLIDAY ACCRUAL	0		33.07
33.08	PRIOR YEAR HOLIDAY ACCRUAL	0		33.08
33.09	CURRENT COMPENSATORY LEAVE ACCRUAL	0		33.09
33.10	PRIOR YEAR COMPENSATORY LEAVE ACCRUA	0		33.10
33.11	LAUNDRY PROVIDED BY 17-4004 OSAWATOM	0		33.11
33.12	OUTSIDE MEDICAL SERVICES	0		33.12
33.13	LAUNDRY COSTS TRANSFERRED FROM 17-40	0		33.13
33.14	LAUNDRY COSTS TRANSFERRED FROM 17-40	0		33.14
33.15	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.15
33.16	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.16
33.17	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.17
33.18	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.18
33.19	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.19
33.20	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.20
33.21	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.21
33.22	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.22
33.23	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.23
33.24	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.24
33.25	OTHER COSTS TRANSFERRED FROM 17-4004	0		33.25
33.26	COSTS TRANSFERRED TO 17-4004	0		33.26
34.00	COSTS TRANSFERRED TO 17-4004	0		34.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 12/27/2012 8:35 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		5.00	ADMINISTRATIVE & GENERAL	KS DEPT OF ADMIN EXP	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	MALP INS PAID BY STATE	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	SRS HOME OFFICE ALLOCATION	3.00
4.00		8.00	LAUNDRY & LINEN SERVICE	PROVIDED BY OSH	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00		G	KS DEPT OF ADMI	0.00		6.00
7.00		G	SRS HOSPITAL AD	0.00		7.00
8.00		G	OSAWATOMIE S H	0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 12/27/2012 8:35 am

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		13,500	0	13,500	0		1.00
2.00		13,561	0	13,561	0		2.00
3.00		26,076	0	26,076	0		3.00
4.00		20,610	20,610	0	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	73,747	20,610	53,137			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/27/2012 8:35 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		30.00	ADULTS & PEDIATRICS	676,998	66,533	1.00
2.00		0.00		0	0	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				676,998	66,533	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/27/2012 8:35 am

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		610,465	154,100	9,948	737,013	36,851	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		610,465		9,948	737,013	36,851	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/27/2012 8:35 am

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	13,561	12,228	749,241	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	13,561	12,228	749,241	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 12/27/2012 8:35 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	66,533		1.00
2.00		0	0		2.00
3.00		0	0		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	66,533		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	121,312	121,312				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,406		5,406			2.00
4.00	00400	EMPLOYEE BENEFITS	2,000,781	603	27	2,001,411		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	481,247	35,082	1,563	45,694	563,586	5.00
6.00	00600	MAINTENANCE & REPAIRS	262,720	1,004	45	37,317	301,086	6.00
7.00	00700	OPERATION OF PLANT	125,069	8,083	360	0	133,512	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,794	0	0	0	79,794	8.00
9.00	00900	HOUSEKEEPING	151,795	201	9	61,165	213,170	9.00
10.00	01000	DIETARY	277,395	3,449	154	0	280,998	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	183,098	201	9	85,797	269,105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,171	603	27	0	54,801	14.00
15.00	01500	PHARMACY	39,366	0	0	0	39,366	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	178,317	1,004	45	80,370	259,736	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,535,037	70,542	3,143	1,632,931	5,241,653	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,884	0	0	0	15,884	54.00
60.00	06000	LABORATORY	58,370	0	0	13,958	72,328	60.00
66.00	06600	PHYSICAL THERAPY	278	0	0	0	278	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,899	0	0	0	3,899	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243,170	540	24	44,179	287,913	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	128,031	0	0	0	128,031	89.02
90.00	09000	CLINIC	90,005	0	0	0	90,005	90.00
91.00	09100	EMERGENCY	32,370	0	0	0	32,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,067,515	121,312	5,406	2,001,411	8,067,515	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,067,515	121,312	5,406	2,001,411	8,067,515	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	563,586					5.00
6.00	00600	MAINTENANCE & REPAIRS	22,613	323,699				6.00
7.00	00700	OPERATION OF PLANT	10,027	30,921	174,460			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,993	0	0	85,787		8.00
9.00	00900	HOUSEKEEPING	16,010	768	458	0	230,406	9.00
10.00	01000	DIETARY	21,104	13,194	7,862	0	10,410	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	20,211	768	458	0	606	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,116	2,305	1,374	0	1,819	14.00
15.00	01500	PHARMACY	2,957	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,507	3,842	2,289	0	3,031	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	393,678	269,834	160,787	85,787	212,909	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,193	0	0	0	0	54.00
60.00	06000	LABORATORY	5,432	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	21	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	293	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,624	2,067	1,232	0	1,631	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	9,616	0	0	0	0	89.02
90.00	09000	CLINIC	6,760	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,431	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	563,586	323,699	174,460	85,787	230,406	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	563,586	323,699	174,460	85,787	230,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	333,568					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	291,148		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	64,415	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	333,568	0	0	291,148	64,415	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	333,568	0	0	291,148	64,415	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	333,568	0	0	291,148	64,415	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	42,323					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	288,405				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,323	288,405	7,384,507	0	7,384,507	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	17,077	0	17,077	54.00
60.00	06000	LABORATORY	0	0	77,760	0	77,760	60.00
66.00	06600	PHYSICAL THERAPY	0	0	299	0	299	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	4,192	0	4,192	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	314,467	0	314,467	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	0	137,647	0	137,647	89.02
90.00	09000	CLINIC	0	0	96,765	0	96,765	90.00
91.00	09100	EMERGENCY	0	0	34,801	0	34,801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,323	288,405	8,067,515	0	8,067,515	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	42,323	288,405	8,067,515	0	8,067,515	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	603	27	630	630	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	35,082	1,563	36,645	14	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,004	45	1,049	12	6.00
7.00	00700	OPERATION OF PLANT	0	8,083	360	8,443	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	201	9	210	19	9.00
10.00	01000	DIETARY	0	3,449	154	3,603	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	201	9	210	27	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	603	27	630	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,004	45	1,049	25	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	70,542	3,143	73,685	515	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	4	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	540	24	564	14	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	121,312	5,406	126,718	630	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	121,312	5,406	126,718	630	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,659					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,471	2,532				6.00
7.00	00700	OPERATION OF PLANT	652	242	9,337			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	390	0	0	390		8.00
9.00	00900	HOUSEKEEPING	1,041	6	25	0	1,301	9.00
10.00	01000	DIETARY	1,373	103	421	0	59	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,315	6	25	0	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268	18	74	0	10	14.00
15.00	01500	PHARMACY	192	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,269	30	123	0	17	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,608	2,111	8,603	390	1,203	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	78	0	0	0	0	54.00
60.00	06000	LABORATORY	353	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	19	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,406	16	66	0	9	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	625	0	0	0	0	89.02
90.00	09000	CLINIC	440	0	0	0	0	90.00
91.00	09100	EMERGENCY	158	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,659	2,532	9,337	390	1,301	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	36,659	2,532	9,337	390	1,301	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	5,559					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,586		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,000	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,559	0	0	1,586	1,000	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,559	0	0	1,586	1,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,559	0	0	1,586	1,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	192					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,513				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	192	2,513	122,965	0	122,965	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	78	0	78	54.00
60.00	06000	LABORATORY	0	0	357	0	357	60.00
66.00	06600	PHYSICAL THERAPY	0	0	1	0	1	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	19	0	19	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,075	0	2,075	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	0	625	0	625	89.02
90.00	09000	CLINIC	0	0	440	0	440	90.00
91.00	09100	EMERGENCY	0	0	158	0	158	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	192	2,513	126,718	0	126,718	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	192	2,513	126,718	0	126,718	202.00

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	60,390					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		60,390				2.00
4.00	00400	EMPLOYEE BENEFITS	300	300	4,271,172			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,464	17,464	97,514	-563,586	7,503,929	5.00
6.00	00600	MAINTENANCE & REPAIRS	500	500	79,637	0	301,086	6.00
7.00	00700	OPERATION OF PLANT	4,024	4,024	0	0	133,512	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	79,794	8.00
9.00	00900	HOUSEKEEPING	100	100	130,532	0	213,170	9.00
10.00	01000	DIETARY	1,717	1,717	0	0	280,998	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	100	100	183,098	0	269,105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	300	300	0	0	54,801	14.00
15.00	01500	PHARMACY	0	0	0	0	39,366	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	500	500	171,517	0	259,736	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,116	35,116	3,484,805	0	5,241,653	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	15,884	54.00
60.00	06000	LABORATORY	0	0	29,787	0	72,328	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	278	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3,899	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	269	269	94,282	0	287,913	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	0	0	0	128,031	89.02
90.00	09000	CLINIC	0	0	0	0	90,005	90.00
91.00	09100	EMERGENCY	0	0	0	0	32,370	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,390	60,390	4,271,172	-563,586	7,503,929	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	121,312	5,406	2,001,411		563,586	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.008809	0.089518	0.468586		0.075105	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			630		36,659	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000148		0.004885	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	42,126					6.00
7.00	00700	OPERATION OF PLANT	4,024	38,102				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	42,247			8.00
9.00	00900	HOUSEKEEPING	100	100	0	38,002		9.00
10.00	01000	DIETARY	1,717	1,717	0	1,717	33,822	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	100	100	0	100	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	300	300	0	300	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	500	500	0	500	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,116	35,116	42,247	35,116	33,822	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	269	269	0	269	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,126	38,102	42,247	38,002	33,822	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	323,699	174,460	85,787	230,406	333,568	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.684067	4.578762	2.030606	6.062997	9.862456	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,532	9,337	390	1,301	5,559	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.060105	0.245053	0.009231	0.034235	0.164360	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,080			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	44,495		14.00
15.00	01500	PHARMACY	0	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,080	44,495	100	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89.01	08901	FQHC II	0	0	0	0	0	89.01
89.02	08902	FQHC III	0	0	0	0	0	89.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	2,080	44,495	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	291,148	64,415	42,323	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	139.975000	1.447691	423.230000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	1,586	1,000	192	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.762500	0.022474	1.920000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 12/27/2012 8:35 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,214,178		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,214,178		30.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
66.00	06600	PHYSICAL THERAPY	0		66.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
68.01	06802	OUTSIDE MEDICAL COST	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
89.01	08901	FQHC II	0		89.01
89.02	08902	FQHC III	0		89.02
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0		99.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
116.00	11600	HOSPICE	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,214,178		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	288,405		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.046411		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,513		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000404		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:35 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,384,507		7,384,507	0	7,384,507	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,077		17,077	0	17,077	54.00
60.00	06000	LABORATORY	77,760		77,760	0	77,760	60.00
66.00	06600	PHYSICAL THERAPY	299	0	299	0	299	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	4,192		4,192	0	4,192	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	314,467		314,467	0	314,467	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
89.01	08901	FQHC II	0		0	0	0	89.01
89.02	08902	FQHC III	137,647		137,647	0	137,647	89.02
90.00	09000	CLINIC	96,765		96,765	0	96,765	90.00
91.00	09100	EMERGENCY	34,801		34,801	0	34,801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	8,067,515	0	8,067,515	0	8,067,515	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	8,067,515	0	8,067,515	0	8,067,515	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:35 am

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		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,214,178		6,214,178			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,873	0	1,873	9.117459	0.000000	54.00
60.00	06000	LABORATORY	76,784	6,000	82,784	0.939312	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	279	0	279	1.071685	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,075	0	3,075	1.363252	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	265,801	0	265,801	1.183092	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
89.01	08901	FQHC II	0	0	0			89.01
89.02	08902	FQHC III	79,602	0	79,602			89.02
90.00	09000	CLINIC	145,380	0	145,380	0.665600	0.000000	90.00
91.00	09100	EMERGENCY	32,370	0	32,370	1.075100	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	6,819,342	6,000	6,825,342			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,819,342	6,000	6,825,342			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:35 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	9.117459		54.00
60.00	06000	LABORATORY	0.939312		60.00
66.00	06600	PHYSICAL THERAPY	1.071685		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06802	OUTSIDE MEDICAL COST	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	1.363252		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.183092		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
89.01	08901	FQHC II			89.01
89.02	08902	FQHC III			89.02
90.00	09000	CLINIC	0.665600		90.00
91.00	09100	EMERGENCY	1.075100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,384,507		7,384,507	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,077		17,077	0	0	54.00
60.00	06000	LABORATORY	77,760		77,760	0	0	60.00
66.00	06600	PHYSICAL THERAPY	299	0	299	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	4,192		4,192	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	314,467		314,467	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
89.01	08901	FQHC II	0		0	0	0	89.01
89.02	08902	FQHC III	137,647		137,647	0	0	89.02
90.00	09000	CLINIC	96,765		96,765	0	0	90.00
91.00	09100	EMERGENCY	34,801		34,801	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	8,067,515	0	8,067,515	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	8,067,515	0	8,067,515	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,214,178		6,214,178			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,873	0	1,873	9.117459	0.000000	54.00
60.00	06000	LABORATORY	76,784	6,000	82,784	0.939312	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	279	0	279	1.071685	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,075	0	3,075	1.363252	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	265,801	0	265,801	1.183092	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
89.01	08901	FQHC II	0	0	0	0.000000	0.000000	89.01
89.02	08902	FQHC III	79,602	0	79,602	1.729190	0.000000	89.02
90.00	09000	CLINIC	145,380	0	145,380	0.665600	0.000000	90.00
91.00	09100	EMERGENCY	32,370	0	32,370	1.075100	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	6,819,342	6,000	6,825,342			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,819,342	6,000	6,825,342			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 12/27/2012 8:35 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06802	OUTSIDE MEDICAL COST	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
89.01	08901	FQHC II	0.000000		89.01
89.02	08902	FQHC III	0.000000		89.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122,965	0	122,965	11,274	10.91	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	04500	NURSING FACILITY	0		0	0	0.00	45.00
200.00		Total (lines 30-199)	122,965		122,965	11,274		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

	Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
			6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,741	18,994		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	1,741	18,994		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	78	1,873	0.041644	589	25	54.00
60.00	06000	LABORATORY	357	82,784	0.004312	13,202	57	60.00
66.00	06600	PHYSICAL THERAPY	1	279	0.003584	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	19	3,075	0.006179	561	3	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,075	265,801	0.007807	44,013	344	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
89.01	08901	FQHC II	0	0	0.000000	0	0	89.01
89.02	08902	FQHC III	625	79,602	0.007852	0	0	89.02
90.00	09000	CLINIC	440	145,380	0.003027	0	0	90.00
91.00	09100	EMERGENCY	158	32,370	0.004881	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	3,753	611,164		58,365	429	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,274	0.00	1,741	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	0	45.00
200.00		Total (lines 30-199)	11,274		1,741	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III | Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
			12.00	13.00	
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	54.00
60.00	06000	LABORATORY		0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST		0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
89.01	08901	FQHC II		0	0	0	0	89.01
89.02	08902	FQHC III		0	0	0	0	89.02
90.00	09000	CLINIC		0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	92.00
200.00		Total (lines 50-199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,873	0.000000	0.000000	589	54.00
60.00	06000	LABORATORY	0	82,784	0.000000	0.000000	13,202	60.00
66.00	06600	PHYSICAL THERAPY	0	279	0.000000	0.000000	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	3,075	0.000000	0.000000	561	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	265,801	0.000000	0.000000	44,013	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
89.01	08901	FQHC II	0	0	0.000000	0.000000	0	89.01
89.02	08902	FQHC III	0	79,602	0.000000	0.000000	0	89.02
90.00	09000	CLINIC	0	145,380	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	32,370	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	611,164			58,365	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		0	54.00
60.00	06000	LABORATORY	0	5,063	0		0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0		0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0		0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
89.01	08901	FQHC II	0	0	0		0	89.01
89.02	08902	FQHC III	0	0	0		0	89.02
90.00	09000	CLINIC	0	0	0		0	90.00
91.00	09100	EMERGENCY	0	0	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		0	92.00
200.00		Total (lines 50-199)	0	5,063	0		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
89.01	08901	FQHC II	0	0		89.01
89.02	08902	FQHC III	0	0		89.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	9.117459	0	0	0		54.00
60.00	06000	LABORATORY	0.939312	5,063	0	0		60.00
66.00	06600	PHYSICAL THERAPY	1.071685	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0		68.00
68.01	06802	OUTSIDE MEDICAL COST	0.000000	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	1.363252	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.183092	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
89.01	08901	FQHC II	0.000000					89.01
89.02	08902	FQHC III	0.000000					89.02
90.00	09000	CLINIC	0.665600	0	0	0		90.00
91.00	09100	EMERGENCY	1.075100	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0		92.00
200.00		Subtotal (see instructions)		5,063	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		5,063	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs PPS Services (see inst.)	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	4,756	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06802	OUTSIDE MEDICAL COST	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
89.01	08901	FQHC II	0	0	0		89.01
89.02	08902	FQHC III	0	0	0		89.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Subtotal (see instructions)	4,756	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,756	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,274	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,274	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,741	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,384,507	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,384,507	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,214,178	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,214,178	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.188332	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	551.20	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,384,507	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	655.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,140,355	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,140,355	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	70,607	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,210,962	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	18,994	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	429	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	19,423	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,191,539	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	122,965	7,384,507	0.016652	0	0	90.00
91.00	Nursing School cost	0	7,384,507	0.000000	0	0	91.00
92.00	Allied health cost	0	7,384,507	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,384,507	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:35 am

Title XIX | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,274	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,274	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	344	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,384,507	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,384,507	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,214,178	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,214,178	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.188332	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	551.20	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,384,507	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	655.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	225,320	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	225,320	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:35 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	10,623	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	235,943	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 12/27/2012 8:35 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		950,751		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	9.117459	589	5,370	54.00
60.00	06000	LABORATORY	0.939312	13,202	12,401	60.00
66.00	06600	PHYSICAL THERAPY	1.071685	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1.363252	561	765	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.183092	44,013	52,071	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
89.01	08901	FQHC II	0.000000		0	89.01
89.02	08902	FQHC III	0.000000		0	89.02
90.00	09000	CLINIC	0.665600	0	0	90.00
91.00	09100	EMERGENCY	1.075100	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		58,365	70,607	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		58,365		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 12/27/2012 8:35 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		189,544		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	9.117459	0	0	54.00
60.00	06000	LABORATORY	0.939312	1,848	1,736	60.00
66.00	06600	PHYSICAL THERAPY	1.071685	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06802	OUTSIDE MEDICAL COST	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1.363252	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.183092	7,512	8,887	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
89.01	08901	FQHC II	0.000000	0	0	89.01
89.02	08902	FQHC III	1.729190	0	0	89.02
90.00	09000	CLINIC	0.665600	0	0	90.00
91.00	09100	EMERGENCY	1.075100	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		9,360	10,623	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		9,360		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E Part B Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,756	2.00
3.00	PPS payments	2,245	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	2,245	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,245	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,245	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,245	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,245	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,245	40.00
41.00	Interim payments	2,245	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 174010	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 12/27/2012 8:35 am
	Title XVIII	Hospital	PPS

		Overrides
		1.00
	WORKSHEET OVERRIDE VALUES	
112.00	Override of Ancillary service charges (line 12)	0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,113,115		2,245	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,113,115		2,245	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		31,869		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,144,984		2,245	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-3 Part II Date/Time Prepared: 12/27/2012 8:35 am

Title XVIII | Hospital | PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,181,201	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	30.803279	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,181,201	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,181,201	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,181,201	18.00
19.00	Deductibles	53,147	19.00
20.00	Subtotal (line 18 minus line 19)	1,128,054	20.00
21.00	Coinsurance	57,439	21.00
22.00	Subtotal (line 20 minus line 21)	1,070,615	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	106,241	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	74,369	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	76,451	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,144,984	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,144,984	31.00
32.00	Interim payments	1,113,115	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	31,869	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-3 Part VII Date/Time Prepared: 12/27/2012 8:35 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	235,943		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	235,943	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	235,943	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	189,544		8.00
9.00	Ancillary service charges	9,360	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	198,904	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	198,904	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	37,039	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	198,904	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	198,904	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	37,039	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	198,904	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	198,904	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	198,904	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	198,904	0	40.00
41.00	Interim payments	89,468	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	109,436	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G | Date/Time Prepared: 12/27/2012 8:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,367,870	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	269,418	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,637,288	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	390,000	0	0	0	12.00
13.00	Land improvements	400,266	0	0	0	13.00
14.00	Accumulated depreciation	-399,786	0	0	0	14.00
15.00	Buildings	5,885,957	0	0	0	15.00
16.00	Accumulated depreciation	-4,917,079	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	491,293	0	0	0	19.00
20.00	Accumulated depreciation	-396,024	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,454,627	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	3,091,915	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	39,497	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	39,497	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	39,497	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	3,052,418				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	3,052,418	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	3,091,915	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 12/27/2012 8:35 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		-2,227,247		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,279,665				2.00
3.00	Total (sum of line 1 and line 2)		3,052,418		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,052,418		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,052,418		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 12/27/2012 8:35 am

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)		0		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		0		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/27/2012 8:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,214,178		6,214,178	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,214,178		6,214,178	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,214,178		6,214,178	17.00
18.00	Ancillary services	573,854	6,000	579,854	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
21.01	FQHC II	0	0	0	21.01
21.02	FQHC III	0	0	0	21.02
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,788,032	6,000	6,794,032	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		7,452,772		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		7,452,772		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 174010 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-3 | Date/Time Prepared: 12/27/2012 8:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	6,794,032	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	6,794,032	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	7,452,772	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-658,740	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	2,791	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	814	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	5,934,800	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	5,938,405	25.00
26.00	Total (line 5 plus line 25)	5,279,665	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,279,665	29.00